MIPS Quality Performance Category

In general, to receive a quality performance score and qualify for a potential MIPS upward payment adjustment, clinicians must report on at least 6 measures, including one outcomes measures or another high priority measure (appropriate use, patient safety, efficiency, patient experience, or care coordination measure) if an outcomes measures is not available. In general, this category contributes to 50 percent of your MIPS Final Score for 2018.

For 2018, clinicians must report on each measure for 60% of applicable patients (Medicare-only for claims reporting; all-payer data for qualified registry, QCDR, and EHR) for the full 2018 calendar year. The clinician also must have at least 20 applicable patients for a given measure in order to receive a performance score higher than an automatic 3-point score given for simply reporting a measure with sufficient data completeness. Measures not meeting the 60% data completeness threshold can only earn 1 point, except for clinicians that are part of a small practice (in which case the measures will receive a 3 points).

Measures that do meet these case size and data completeness requirements will be assessed against national performance benchmarks to determine how many points the measure earns. A clinician can receive anywhere from 3 to 10 points for each measure, as well as additional bonus points (up to a cap) available for reporting on additional high priority measures and/or using end-to-end electronic reporting to submit such measures. For 2018, benchmarks are based on actual performance data submitted to PQRS in 2016, where available.

For group practices with more than 15 MIPS eligible clinicians, CMS will automatically calculate a 30-day All-Cause Hospital Readmission measure based on administrative claims. This measure is a risk-standardized readmission rate for beneficiaries age 65 or older who were hospitalized at a short-stay acute care hospital and experienced an unplanned readmission for any cause to an acute care hospital within 30 days of discharge. CMS will only score a group practice on this measure if at least 200 cases are attributed to the group based on the measure specifications. This measure requires no additional data submission on the part of the practice.

To achieve a maximum score in the Quality category, clinicians would either have to earn the highest possible performance score (i.e., 10 points) on up to 6 reported measures (including at least one outcome or high-priority measure) plus the calculated 30-day All-Cause Hospital Readmission measure, if applicable, or supplement less than perfect performance with bonus points available for reporting on high priority measures (1-2 points, up to a cap) or end-to-end electronic reporting of such measures (1 point, up to a cap).

Example:
Measure A = 10/10 points
Measure B (outcomes measure) = 10/10 points
Measure C = 10/10 points
Measure D (additional high priority measure) = 8/10 points + 1 bonus point
Measure E = 8/10 points
Measure F (less than 20 patients- measure unable to be scored) = 3/10 points
Measure G (All-Cause Hospital Readmission measure) = 8/10 points
TOTAL Score = (57+1/70 points) x (quality category weight of 50 points) =
41 points toward the total MIPS composite score of 100

While CMS encourages the reporting of 6 measures, it recognizes that certain specialties do not have 6 relevant measures. CMS will use a process called the Eligible Measures Applicability (EMA) process[1] to determine whether there were truly no other measures available to a clinician who reports on fewer than 6 measures. If CMS determines that to be true, it will recalibrate the weight of each measure so that the clinician may still earn up to the maximum performance score for the Quality category.

Example:
Measure A = 10/10 points
Measure B (outcomes measure) = 10/10 points
Measure C = 8/10 points
TOTAL SCORE = (28/30 points) x (quality category weight of 50 points) =
47 points toward total MIPS score

For 2018, clinicians can only be scored on measures reported via a single reporting mechanism. In other words, a clinician cannot be scored on 3 measures submitted via claims and 3 measures submitted via registry. Clinicians are encouraged to choose a single reporting mechanism. However, if a clinician submits measures via multiple reporting mechanisms, CMS will calculate a score for each mechanism and use whichever is highest. Keep in mind that this policy is expected to change in 2019, when CMS intends to accept data from multiple submission mechanisms for any single performance category. AAHPM will post information on this new policy when it becomes available.

Quality Measures

There are currently over 250 measures in the MIPS quality measure inventory. To help clinicians navigate this list and find measures most relevant to their practice, CMS created specialty and subspecialty measure sets. Clinicians are not required to report from these sets – they are merely suggestions. There are currently no specialty sets related specifically to hospice or palliative care. However, other sets might be relevant depending on each clinician's type of practice. More detailed measure specifications are available for download here.

Some MIPS measures that might be relevant to HPM clinicians include:

- #47: Care Plan (claims, registry)
- #130: Documentation of Current Medications in the Medical Record (claims, registry, EHR)
- #143: Oncology: Medical and Radiation- Pain Intensity Qualified (registry, EHR)
- #144: Oncology: Medical and Radiation- Plan of Care for Pain (registry)
- #342: Pain Brought Under Control Within 48 Hours (registry)
- #386: ALS Patient Care Preferences- percentage of patients diagnosed with ALS who were offered assistance in planning for end of life issues (registry)
- #453: Proportion of Patients Receiving Chemotherapy in the Last 14 Days of Life (registry)
- #454: Proportion of Patients Who Died from Cancer with >1 ED visit in last 30 days of life (registry)
- #455: Proportion of Patients Admitted to ICU in Last 30 days of Life (registry)
- #456: Proportion of Patients Who Died from Cancer Not Admitted to Hospice (registry)

[1] Note that the EMA process is somewhat similar to the Measures Applicability Validation (MAV) process used under PQRS, but it does not take an all-or-nothing approach for providing credit under the MIPS quality performance category; rather, submitters still receive credit for the measures submitted.

- #457: Proportion of Patients Who Died from Cancer Admitted to Hospice for Less than 3 days (registry)

Note that clinicians and groups that opt to participate in a Qualified Clinical Data Registry (QCDR) to submit quality data will have access to additional non-MIPS measures developed by the QCDR that might be more relevant to a specialist's practice. A list of QCDRs qualified for 2018 MIPS reporting is available for download here. 2018 QCDR measure specifications, searchable by specialty and clinical category, are available for download here. A list of approved Qualified Registries is also available here.